Election of Medicaid Hospice Benefit

I, _____, elect to
(Patient Name/MAID#)
receive the Medicaid Hospice Benefit from _____
(Facility Name) (Provider Number)
this _____ day of _____, 20____. I am aware that my disease is incurable. I consent to the management of the symptoms of my disease by _____. My family and I will help to develop a plan of care based on our needs. My care will be supervised by my attending physician, _____, and the Hospice Director. My outpatient medications will be provided by _____.

I may receive benefits which include home nursing visits, counseling, medical social work services, medical supplies and equipment. If needed, I may also receive home health aides/homemakers, physical therapy, occupational therapy, speech/language pathology, in-patient care for acute symptoms, medical procedures ordered by my physician and hospice, and continuous nursing care in the home in acute medical crisis.

I may request volunteer services, when available.

I realize that my family and I have the opportunity for limited respite or relief care in a nursing facility.

In accepting these services, which are more comprehensive than regular Medicaid benefits, I waive my right to regular benefits except for payment to my attending physician, treatment for medical conditions unrelated to my terminal illness, medical transportation, nurse anesthetist, or dental.

I understand that I can revoke this benefit at any time and return to regular Medicaid benefits. I understand, if I terminate the Medicaid Hospice Benefit, I can resume regular Medicaid if I am still eligible.

I understand that the Hospice benefit is a home care program. If my family and I choose care not available from the Hospice Agency I understand that the Hospice and the Medicaid Program are not financially responsible.

I understand that the Hospice Benefit consists of two 90-day periods, and an unlimited number of 60-day periods.

I understand that at the end of any benefit period, because of an improvement in my condition, I may choose to save the remainder of the benefit period(s). I may revoke the Hospice Benefit at this time.

I also understand that should I choose to do so, I am still eligible to receive the remaining benefit period(s); I am aware, however, that if I choose to revoke Hospice Benefits during a benefit period, I am not entitled to coverage for the remaining days of that benefit period.

I understand that if I choose to do so, once during each election period I may change the designation of the particular hospice from which hospice care will be received by filing a statement with the hospice from which care has been received and with the newly designated hospice. I understand that a change of hospice providers is not a revocation of the remainder of that election period.

I understand that, unless I revoke the Hospice Benefit, hospice coverage will continue indefinitely.

I understand that I may be responsible for Hospice charges if I become ineligible for Medicaid services.

Check one:

☐ I am a Medicare recipient and have elected to use the Medicare Hospice Benefit. My Medicare eligibility for Hospice benefits begins _____.

☐ I am a Medicare recipient with Part B benefits only, which does not include Hospice coverage.

☐ My Medicare Hospice Benefits have been exhausted as of _____.
(Date)

☐ I am not a Medicare recipient.

☐ I am currently a Nursing Facility resident, residing at:

_____.
(Facility Name/Address) (Facility Provider Number)

Hospice Benefit Election

_____	_____
Patient's Signature or Mark	Patient's Name (Print or Type)
_____	_____
Witness' Signature	Relationship to Patient
_____	_____
Date Signed	Effective Date of Election

Second Benefit Period: (To be signed only if benefits previously revoked or temporarily terminated.)

_____	_____
Patient's Signature or Mark	Patient's Name (Print or Type)
_____	_____
Witness' Signature	Relationship to Patient
_____	_____
Date Signed	Effective Date of Second Period

Additional Benefit Period: (To be signed only if benefits previously evoked or temporarily terminated.)

_____	_____
Patient's Signature or Mark	Patient's Name (Print or Type)
_____	_____
Witness' Signature	Relationship to Patient
_____	_____
Date Signed	Effective Date of _____ Period*

Additional Benefit Period: (To be signed only if benefits previously revoked or temporarily terminated.)

_____	_____
Patient's Signature or Mark	Patient's Name (Print or Type)
_____	_____
Witness' Signature	Relationship to Patient
_____	_____
Date Signed	Effective Date of _____Period*

Additional Benefit Period: (To be signed only if benefits previously revoked or temporarily terminated.)

_____	_____
Patient's Signature or Mark	Patient's Name (Print or Type)
_____	_____
Witness' Signature	Relationship to Patient
_____	_____
Date Signed	Effective Date of _____Period*

*Please identify benefit period (third, fourth, fifth, etc.)

MAP-384 (Rev. 9/92)

KENTUCKY MEDICAID PROGRAM
HOSPICE DRUG FORM

1. Recipient Las Name	2. First Name	3. Medical Assistance I.D. No.

4. Date Medicaid Hospice Coverage Began	5. (1) First Diagnosis (Not Related to Terminal Illness)	ICD.9 CM Code
6. Total Number of Prescriptions Not Related to Terminal Illness	(2) Second Diagnosis (Not Related to Terminal Illness)	ICD.9 CM Code

7. Drug Name Manufacture/Strength (10 mg, 15 ml, etc.)	8. NDC #	9. Units	10. Price Per Unit	11. Total Charge	12. Medicaid Maximum Allowance (Leave Blank)

13. Date Span for Which These Prescriptions are Requested	14. Total Units This Invoice		15. Total Charge This Invoice	16. Dispensing Fee Total
_____ From _____ To				

17. Terminal Diagnosis	ICD.9 CM Code	18. Did Patient Require These Prescriptions Prior to Diagnosis of Terminal Illness? _____ Yes _____ No

19. Are These Prescriptions the Result of Hospitalization not Related to Terminal Illness? _____ Yes _____ No	20. If Yes, Dates of Hospitalization: _____ From _____ To
21. Name of Hospital	22. Prescribing Physician _____

23. PROVIDER CERTIFICATION AND SIGNATURE: This is to certify that the prescriptions entered above are not related to the terminal illness of this recipient.

_____
Signed

24. PROVIDER NAME AND ADDRESS	25. PROVIDER NUMBER	26. INVOICE DATE	27. INVOICE NUMBER

DOCUMENTATION INDICATING THAT THESE PRESCRIPTIONS ARE NOT RELATED TO THE PATIENT'S TERMINAL DIAGNOSIS MUST BE ATTACHED